spondence. The non-medical subjects include use of dictating machines, medical office accounting, collections and credit, preparation of insurance and industrial commission forms, office management, social security and taxes, telephone techniques, purchasing supplies and services, malpractice insurance, role of the detail man and grooming and personal development.

In the near future, there may be set up national computer systems for all patients in the United States to facilitate more complete patient histories. Automated billing is already in effect in some areas. Central record controls are obviously around the corner. Computerized and electronic equipment will obviously continue to be increasingly important in day-to-day practice. The Medical Assistants Association is well aware of the need for all aides to be familiar with the operation of these varied types of electronic equipment.

The physician's partner in the care of the sick warrants the utmost interest and cooperation by the physician. Much closer liaison between individual physicians and medical assistants associations is needed. More physicians should encourage their assistants to be members of an organization dedicated to improving themselves by constant education and training. A physician investing dues for his aides in this organization would receive countless returns on his investment.

Although numerous attempts have been made to unionize our assistants, they still insist on staying out of labor organizations. As physicians individually and as members of our county, state, and national medical association, we must continue to support the Medical Assistants Association. If we expect loyalty from our assistants, we need to be loyal to them. Have you urged and sponsored your aides to membership in the Medical Assistants Association?

Dentist-Physician Relationship In Extended Care Facilities

THE HOSPITAL DENTAL SERVICE Committee of California Dental Association and Southern California Dental Association, meeting in joint session on 9 November 1966 in Los Angeles, developed the following statement defining the obligations of the dentist concerning services for patients in Extended Care Facilities, Nursing Homes, Convalescent Hospitals, etc., under the Medicare and Medi-Cal programs. A firm understanding of the dentist-physician relationship will obviate the need for stringent controls by government agencies.

Dentists rendering care to patients in extended health care facilities, nursing and convalescent homes who need other medical services should consult with the patient's physician so that the total health of the patient may be considered.

Procedures to implement dentist-physician consultations should be established in each facility so as to allow the dentist freedom to carry out his responsibility for the dental health of the patient without jeopardizing the physician's concern for the patient's physical and emotional condition. Special emphasis should be placed on consultation where the administration of drugs and anesthetic agents is contemplated.

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Federalized Health Care Systems in Western Europe And Australia

A Report of the Bureau of Research and Planning, California Medical Association

CURRENT LEGISLATIVE action, including passage of P.L. 89-97, which contains provisions for health benefits for the aged, necessitates review of the responsibility assumed in other countries by government for the financing and provision of health care, if only to become acquainted with programs of these other countries. The object of this *Report* is to describe the nature, organization, and distribution of health benefits in several countries, largely in Western Europe, but including also the unique system found in Australia. No attempt is made to compare in a critical fashion the varied systems

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discussed, although descriptions of programs in selected countries may provide some clues to future directions in the United States.

As of May 1964, 64 countries throughout the world, including all European nations, had some type of sickness insurance and benefit program.[11] Generally, in Western Europe, these benefits include old age, medical care, cash sickness, survivor, maternity, invalidity, family allowance, and unemployment benefits. This *Report,* however, considers only the financing of medical care and cash provisions for illness; no qualitative judgment is made on the various systems. The intent of this paper is to provide a summary and comparison of certain aspects of medical provision in selected countries. However, a brief outline of some of the problems common to these systems may be useful to the reader in evaluating the information presented.

Difficulties have been encountered in some countries in coordinating different aspects of health services, particularly where responsibility is shared by two or more governmental agencies; the reconciliation of professional freedom with government supervision has occasionally proved troublesome; and provision of the best possible medical care may conflict with the need for economy in public expenditure.[3] (For a discussion of professional problems in federalized health care abroad, the reader is referred to CALIFORNIA MEDICINE, 104:146-151, February 1966.)

Payment of the physician may be handled by a number of methods, from salaried service to fee-for-service, typified respectively by the U.S.S.R. and the United States. Other systems include: capitation, a regular payment to the physician for each of a group of patients, with free contractual relationships, as found in the United Kingdom; case payment, where the doctor is paid by the financing organization according to the number of patients seen in a given period; and fee-for-service, where payment based on a set scale is given for actual services performed. In this case, payment may be made either by the patient, who is then reimbursed in whole or in part, or directly by the financing organization.[5]

Certain aspects of health care services are covered in more depth in most European countries than under P.L. 89-97. For example, dental care, eye glasses and examinations, prosthetic devices, and hearing aids are regularly covered under most European systems but are excluded under Medicare. Most European systems provide unlimited hospitalization benefits from the onset of illness, while Medicare provides 90 days of hospitalization per illness, with a $40 deductible, and $10 per day from the 61st through the 90th days of hospitalization. Medicare covers a much more narrow segment of the population—those 65 and over—than do European systems.

Organization and financing of health services in France, Germany, Italy, Sweden, the United Kingdom, and Australia[1,2,4,6-10] are described briefly below.

In *France,* comprehensive state-controlled health insurance applies automatically to about nine-tenths of the population, including all paid workers, their families, and all pensioners and the unemployed (although to be eligible for cash benefits the recipient must have worked at least 60 hours in the three months prior to the onset of illness). Participation by individuals not covered automatically is voluntary. Employees and employers participate in the administration of the program, which is organized on three levels: local funds make benefit payments and receive deposits; medical and hospital rates to be paid are set by agreement with the medical association at the regional level; and payments to local groups and coordination of the entire program are made at the national level.

The patient has free choice of doctor and hospital; all doctors and public hospitals and many private hospitals participate.

The program is financed with funds from the single payment made monthly to the overall social security program. This payment averages 20.25 per cent of the worker's income (6 per cent paid by the worker and 14.26 per cent by his employer), and may run as high as 35 per cent. Although the State makes no contribution, it may make advances to the fund. Deficits in the national fund are made up by general taxation.

Unlimited health benefits begin at the onset of illness; the patient pays the doctor directly and is reimbursed for 80 to 100 per cent of physician and hospital expenditures. However, after one month in the hospital, or, in case of long-term illness or three months absence from work, the patient pays no hospital bills at all. Dental, orthodontic, and drug bills are also reimbursed in large measure. Cash payments during illness are made up to 12 months in any three year period, amounting to 50 to 66.67 per cent of salary, based on severity of illness and number of dependents. Pensioners continue to receive full benefits during illness.

In *West Germany,* the health insurance program, although privately run, is state supervised. Local organizations receive contributions, make payments, and supervise the operations, under a Federal association. The individual belongs to the compulsory plan at his place of employment or residence; provisions are also made for voluntary membership of those not automatically enrolled. The local organization makes a lump sum payment on a capitation basis to associations representing the physician; these associations pay the individual physician for items of service under an official fee schedule. The patient has a free choice of approved doctors and hospitals.

Employer and employee each contribute one-half of an amount equal to 8 to 11 per cent of the worker's salary, up to $165 a month. The Federal Government contributes only for the unemployed; the state does not contribute, except to make up deficits.

In order to be eligible for benefits, the worker must earn less than $1,980 a year; there are no prior work requirements.

Coverage extends from the onset of illness, with benefits for a maximum of 18 months of hospitalization. Dental work, hearing devices, and most drugs are covered completely. Cash benefits of up to 69 per cent of the worker's salary are available up to 78 weeks in any three-year period; the employer pays the difference between the benefits and the full salary for the first six weeks of illness. All workers in Germany receive these benefits regardless of nationality.

In *Italy,* approximately 85 per cent of the population, including all non-government workers, their families, pensioners, and the unemployed are covered by the health insurance program, which is operated by an autonomous administration under the National Government. Management is done by governmental representatives, employers, and the insured. In the framework of this scheme, the National Council supervises the entire program, regional organizations collect and administer funds, and local branches assure availability of medical care and make benefit payments. Benefits are paid from the onset of illness, but for a maximum of six months a year; there is no ceiling on income of participants, and no required period of work prior to illness.

The State contributes nothing to the benefits. Blue collar workers pay 15 per cent of their wages, their employers 7.15 per cent. White collar workers pay 15 per cent, employers 5.15 per cent of wages. These payments are made to the Social Security Administration, and cover all benefits such as old age, maternity, and survivors benefits, in addition to health insurance.

Physicians are either under contract with the Social Security Administration or are paid separately for each patient. In the former case, the patient must select a physician and a hospital associated officially with the health plan; in the latter case he may choose any doctor or hospital, but must pay some of the medical costs himself.

Dental care and most prescription drugs are free, and allowances are made for prosthetic devices, hearing aids, and eyeglasses. There is a separate system for tuberculosis patients, under which complete payment of sanitorium fees and up to 50 per cent of other costs may be paid.

Cash payments of from 22 to 54 per cent of wages are made for a maximum of six months, depending on whether or not hospitalization is necessary, and on number of dependents.

In *Sweden,* the National Social Insurance Board operates the health insurance program through regional and municipal offices, hospitals, and public assistance committees. Public officers at regional and national levels are responsible for policy making and administration. All persons, including housewives and the self-employed, are eligible to participate. Under this system, the patient pays the physician, and is reimbursed 75 per cent of the standard fee by the regional office. Fee schedules are worked out by the government, in cooperation with the Swedish Medical Association. Social assistance service is available for those who cannot afford to make use of the regular service.

There is no time limit on hospitalization or medical services, except for the patient over 67 years of age or on an old age or retirement pension, in which case maximum duration of hospitalization is 180 days. Cash benefits vary from 45c to $4.50 a day, depending on income and level of contributions.

Contributions by the worker cover about half the flat premium rate, and the Government and the employer each pay about one-fourth. Cost of insurance varies regionally and with the amount of earnings. Fifty per cent of the cost of cash benefits, and refunds on doctors' fees, as well as part of the cost of drugs and medicine, most hospital costs, and contributions for the unemployed are paid by the Government.

All doctors and public hospitals participate in the program, and the patient has a free choice

among them. Reduced charges are made in municipal sanitoriums for tuberculosis, mental illness and other protracted conditions, and dental care is free to children.

The *United Kingdom* has a health plan which differs from those found in the rest of Western Europe, in that medical care is not a part of a social insurance system, but a free public service. All residents of Great Britain and Northern Ireland are eligible, without qualification, for health services of all kinds. The Government covers about 80 per cent of the cost of the National Health Service; of the remaining 20 per cent, the employee pays about four-fifths and the employer about one-fifth. An annual fixed fee per patient is paid to the participating physician, regardless of services actually rendered. The patient has a free choice of doctors. Most hospitals are government owned. There is a charge of one shilling (14c) for prescribed medicines. Dental services, eyeglasses, hearing aids, etc., are dispensed through the National Health Service, but the patient shares the cost.

Cash benefits for illness are extended automatically to virtually all employed and self-employed individuals. Housewives and the low-income self-employed may insure if they wish. On the average, workers contribute about $1.34 and employers about $1.60 weekly, to the entire national insurance program (including old-age, survivors, maternity, and unemployment benefits) with the Government paying about one-third of the cost. There is no limit on duration of payments for the worker who has made at least 165 weekly contributions.

Disability payments are made of $11.20 a week, with additional payments for dependents.

Australia combines voluntary insurance with benefit payments from Commonwealth Funds. Payments are administered through voluntary insurance agencies under the Australian Medical Plan. Only a small Government staff is utilized; most paper work is conducted by the insurance agencies. No special or separate taxes are levied to support the plan, and all money withheld from checks is voluntary. Under this system, the patient pays the doctor, and receives insurance and Commonwealth benefits on the basis of a statutory schedule, agreed upon by physicians, pharmacists, and the Government, providing fees for specified services. The total charge is always slightly higher than the combined payments of the Commonwealth and insurance.

In order to receive benefits, the patient must be a member of a registered "medical benefits organization," contributing approximately 35c a week for the single person, and about 70c for families. In theory, the Commonwealth and insurance fund should pay a total of 90 per cent of medical expenses, and the patient 10 per cent. In practice, the Commonwealth averages payments of 28 per cent, insurance of 34 per cent, and the patient of 38 per cent. In 1964, approximately 75 per cent of the population was covered under this scheme.

Under this system, the patient has a free choice of physician; he makes his own arrangements, pays the bill, obtains a claims form from his benefit organization, and sends it in, with the doctor's receipt, to his insurance agency. Payment of both Commonwealth and insurance benefits is made by the organization, usually by mail, but sometimes on the spot. If the patient is unable to pay the physician, the organization may handle payment directly.

Sickness benefits of up to about $11.55 a week are payable after a waiting period of one week, for the duration of the illness.

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